

# The Bustier Lower Lid Blepharoplasty

# 72

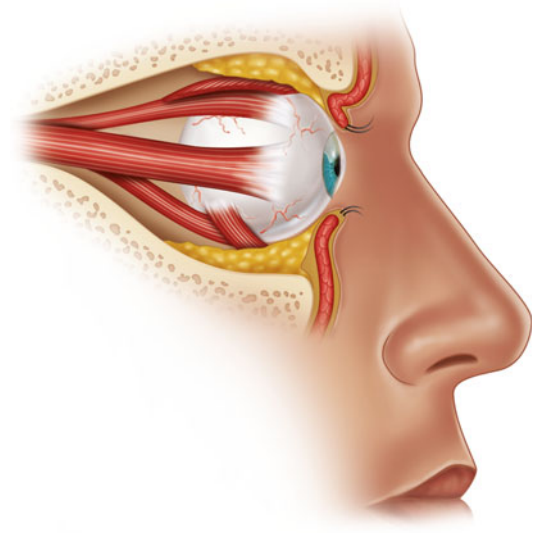
John P. Fezza

There are multiple factors responsible for the changes observed in the aging lower eyelid, and rejuvenation of this area can be challenging. Resorption of the orbital bones causes a widening of the orbital aperture and a resulting hollowing of the periorbital area. The orbital septum which is attached to the maxillary bone is stretched downward with these bony changes, and it becomes weakened and attenuated. This causes lower lid to lengthen and the orbital fat in the lower lid to herniate forward (Figs. 72.1 and 72.2). The resultant appearance is a bag along with a hollow at the junction of the orbital rim due to concomitant soft tissue descent and deflation. Atrophy of the orbicularis muscle combined with elastotic and collagen degradation of the skin can further give the aged lower lid a sagging and wrinkled appearance.

The goal of a lower lid blepharoplasty is to smooth the transition between the cheek and lid recreating a youthful contour. Minimizing bagging, hollows, and skin wrinkles is critical as well as restoring a vertically shorter lower lid. Filling the lower lid-cheek junction with fat provides a correction of the inferior orbital hollows. It also

replaces lost volume and aids to boost the lower lid from below providing support. The lower lid and malar region must be addressed as a continuum; therefore, it is paramount to assess and treat both areas during lower lid rejuvenation.

Microfat is injected in small aliquots in multiple passes from various directions deep to the orbicularis muscle to avoid lumping (Figs. 72.3 and 72.4). Placement of the fat should span the inferior orbital rim and septum, creating a buttress and adding strength and support to a weakened orbital septum (Fig. 72.5). This will reduce the bag and soften the hollow of the lid improving

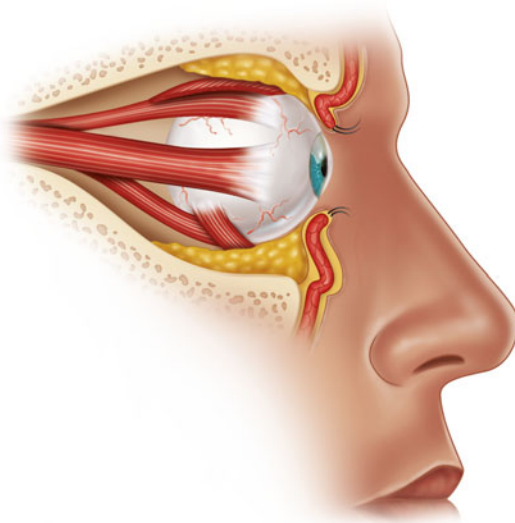


**Fig. 72.1** Sagittal view of youthful lower lid contour

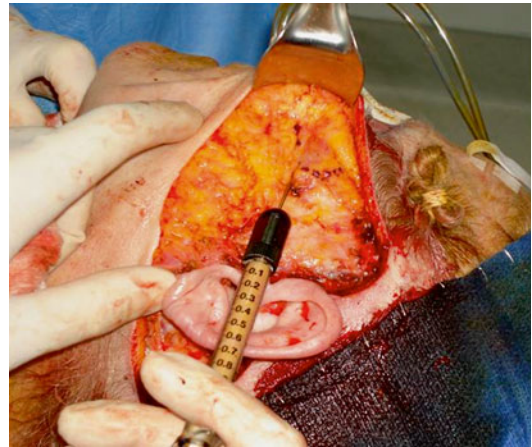
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J.P. Fezza, MD  
Cosmetic Services, Center for Sight,  
Sarasota, FL, USA

Department of Ophthalmology,  
University of South Florida, Tampa, FL, USA  
e-mail: [jfezza@verizon.net](mailto:jfezza@verizon.net)



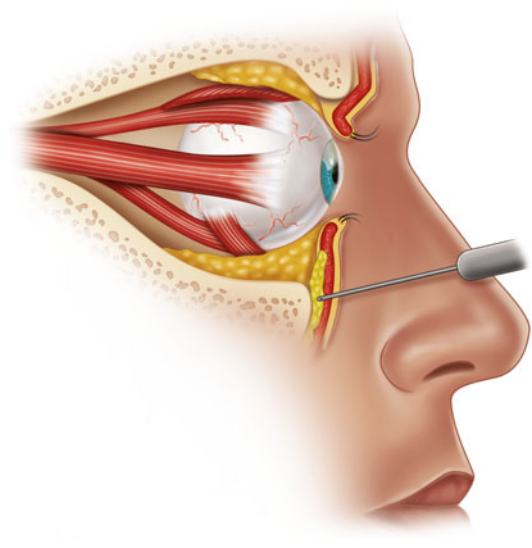
**Fig. 72.2** Sagittal view of aged lower lid with maxillary loss, stretching of the septum, and consequent bag formation



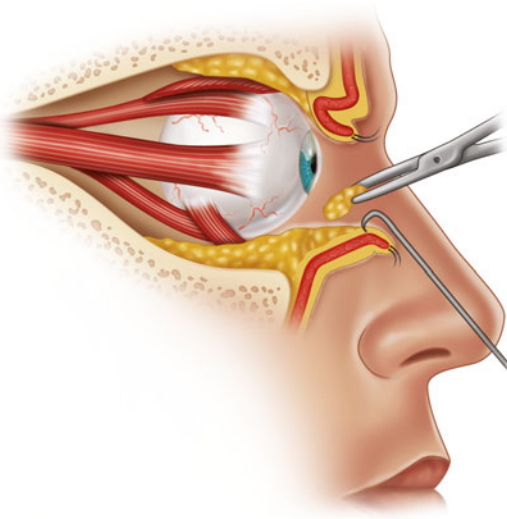
**Fig. 72.4** Left lateral facelift view. Skin is raised and fat is injected below the orbicularis muscle, which is marked with blue surgical pen



**Fig. 72.3** Pattern of crisscross microfat deep injections to lid-cheek area shown with blue arrows. Yellow area denotes fat implantation



**Fig. 72.5** Sagittal view of fat injections deep to orbicularis muscle spanning the maxilla and septum



**Fig. 72.6** Transconjunctival fat removal

contour. This has a similar effect on the orbital fat as a bustier or a girdle. Avoidance of injecting fat directly into the lid itself is important as the tissue is extremely thin and subject to visible lumps from the fat. Fat should also be injected into the malar area to restore volume and counteract deflation.

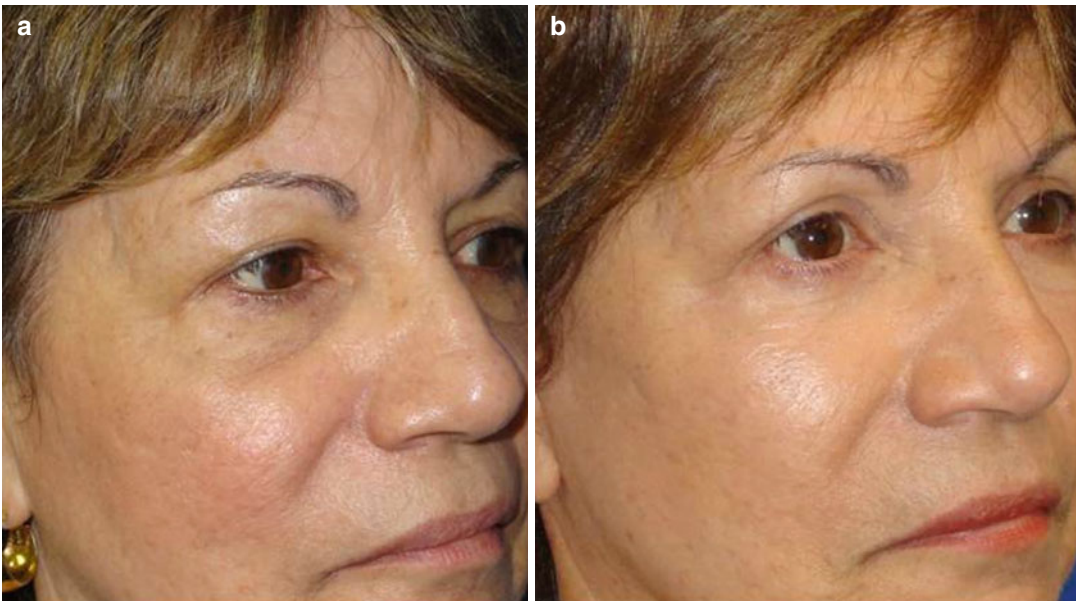
The injected fat presses into the septum from below, flattening it and pushing orbital fat upward and outward. This redundant superior herniated lid fat can be removed transconjunctivally (Fig. 72.6). Lastly, the skin wrinkles can be addressed with laser resurfacing, chemical peel, or a skin pinch. The end result is a rejuvenated lower lid that is shorter with a smooth lid-cheek junction as is seen in a youthful lower lid (Figs. 72.7, 72.8, and 72.9).



**Fig. 72.7** (a) Before blepharoplasty. (b) After bustier blepharoplasty



**Fig. 72.8** (a) Before blepharoplasty. (b) After bustier blepharoplasty



**Fig. 72.9** (a) Before blepharoplasty. (b) After bustier blepharoplasty